

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 4558

Registration District No. 831

Primary Registration District No. 4504

Registrar's No. 2

1. PLACE OF DEATH

(a) County Shelby  
(b) City or town Shelbyville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME CHARLES GIBSON

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Frances Hughes 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased June 1 1863  
(Month) (Day) (Year)

8. AGE: Years 77 Months 7 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Logan Co. Ky. (City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business \_\_\_\_\_

12. Name Corne Gibson

13. Birthplace Shelbyville Ky. (City, town, or county) (State or foreign country)

14. Maiden name Ange Marshall

15. Birthplace Logan Co. Ky. (City, town, or county) (State or foreign country)

16. (a) Informant Theodore Marshall

(b) Address Shelbyville, Mo.

17. (a) Burial (b) Date thereof Jan. 9, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation W.C.B. Cemetery

18. (a) Signature of funeral director E.P. Thompson

(b) Address Shelbyville, Mo.

19. (a) Jan 9-1941 (b) Pearl Gae  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Shelby 102  
(c) City or town Shelbyville 0  
(If outside city or town limits, write "RURAL:") 0  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 7  
year 1941 hour 10:00 minute 0 M.

21. I hereby certify that I attended the deceased from Jan 5, 1941, to Jan 7, 1941.  
that I last saw him alive on Jan 7, 1941.  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Interstitial Nephritis

Due to \_\_\_\_\_

Due to 101

Other conditions Diabetes  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations none

Of autopsy none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 748

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature P.C. Graham (M. D. or other) D

Address Shelbyville Mo. Date signed 1-7-41

Duration

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**RECEIVED**

**District Health Officer No. 10**

District File Number Jan 41-198

Date Filed July 18, 1941

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.